

EXHIBIT G

Estate of Joseph Battaglia

VCF Documentation



September 11th
Victim Compensation Fund

April 2, 2019

PATRICIA BATTAGLIA

[REDACTED]
[REDACTED]

Dear PATRICIA BATTAGLIA:

The September 11th Victim Compensation Fund ("VCF") previously sent you a letter notifying you of the eligibility decision on the claim you submitted on behalf of JOSEPH BATTAGLIA. Your claim number is VCF0048224. The letter explained that the VCF had reviewed your claim and determined you were not eligible for compensation. You then appealed the eligibility decision on your claim and a hearing was held.

The VCF has considered your appeal and has determined that you meet the eligibility criteria established in the statute and regulations. Based on the information you provided in support of your appeal and information the VCF has received from the World Trade Center ("WTC") Health Program, you have been found eligible for the following injuries:

- MALIGNANT NEOPLASM - LUNG WITH METASTASIS

Please note that there are several reasons why an injury that you think should be eligible is not listed above. For non-traumatic injuries, the name of the injury is based on the information provided by the WTC Health Program and there may be different names for the same injury. Additionally, your injury may not be listed if it was only recently certified for treatment by the WTC Health Program.

If in the future the WTC Health Program should notify you that a condition previously found eligible is no longer certified, you must inform the VCF as this may affect your eligibility status and/or loss calculation.

What Happens Next

If the decedent has been certified for treatment by the WTC Health Program for a condition not listed above, you should amend your claim. Please see the VCF website for details on how to amend your claim. The VCF will review the new information and determine if it provides the basis for a revised decision.

If the decedent did not have injuries other than those listed above, you should submit your Compensation Form and required supporting materials. If you have already submitted your Compensation Form, you do not need to take any action at this time unless you receive a request from the VCF for missing information. The VCF will calculate the amount of any compensation based on the conditions listed above after all compensation-related documents are submitted.



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If you have questions about the information in this letter or the claims process in general, please call our toll-free Helpline at 1-855-885-1555. For the hearing impaired, please call 1-855-885-1558 (TDD). If you are calling from outside the United States, please call 1-202-514-1100.

Sincerely,

Rupa Bhattacharyya
Special Master
September 11th Victim Compensation Fund



September 11th
Victim Compensation Fund

February 4, 2020

PATRICIA BYRNES

[REDACTED]

Dear PATRICIA BYRNES:

The September 11th Victim Compensation Fund (“VCF”) sent you a letter on January 08, 2020 notifying you of the decision on your claim and the amount of your award. Your claim number is VCF0048224. That letter included a request for documents that were missing from your claim and are required in order to process your payment. The VCF has since received the requested documents and this letter provides the details of your award and information on the next steps to be taken on your claim.

After reviewing the responses in your claim form, the documents you submitted in support of your claim, and information from third-party entities, the VCF has calculated the amount of your award as [REDACTED]. This determination is in accordance with the requirements of the Never Forget the Heroes: James Zadroga, Ray Pfeifer, and Luis Alvarez Permanent Authorization of the September 11th Victim Compensation Fund Act (“VCF Permanent Authorization Act”). The enclosed “Award Detail” includes a detailed explanation of the calculation and a list of the eligible conditions that were considered when calculating your award.

The VCF has determined that the loss of your husband’s pension benefits, which terminated at his death because benefits were maximized while your husband was alive and no survivor pension option was selected, is not a loss compensable by the VCF.

The VCF calculated lost earnings based on your husband’s wage from the Coast Guard, as he was a member of the Reserve at the time of his death. Because your collateral offsets exceed your total lost earnings, however, the total award includes only non-economic compensation.

As the Personal Representative, you are required to distribute any payment received from the VCF on behalf of the victim to the eligible survivors or other recipients in accordance with the applicable state law or any applicable ruling made by a court of competent jurisdiction or as provided by the Special Master.

What Happens Next

The VCF will deem this award to be final and will begin processing the full payment on your claim unless you complete and return the enclosed Compensation Appeal Request Form within **30 days from the date of this letter** as explained below. If you do not appeal, the Special Master will authorize the payment on your claim within 20 days of the end of the 30-day appeal period. Once the Special Master has authorized the payment, it may take up to three weeks for the United States Treasury to disburse the money into the bank account designated on the VCF ACH Payment Information Form or other payment authorization



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document you submitted to the VCF.

- **Appealing the Award:** You may request a hearing before the Special Master or her designee if you believe the amount of your award was erroneously calculated, or if you believe you can demonstrate extraordinary circumstances indicating that the calculation does not adequately address your loss. **If you choose to appeal, your payment will not be processed until your hearing has been held and a decision has been rendered on your appeal.**

To appeal the award, you must complete two steps by the required deadlines:

1. Complete and return the enclosed **Compensation Appeal Request Form** within **30 days from the date of this letter**. Follow the instructions on the form and upload it to your claim or mail it to the VCF by the required deadline. If you do not submit your completed Compensation Appeal Request Form within 30 days of the date of this letter, *you will have waived your right to an appeal* and the VCF will begin processing any payment due on your claim.
2. Complete and submit your **Compensation Appeal Package** (Pre-Hearing Questionnaire, Compensation Explanation of Appeal, and all applicable supporting documents) no later than **60 days from the date of this letter**. It is important that you carefully review the information enclosed with this letter and follow the instructions if you intend to appeal your award. Additional instructions on the appeals process can be found on the VCF website under “Frequently Asked Questions” and in the “Policies and Procedures” document.

Once your complete Compensation Appeal Package is submitted, the VCF will review the information to confirm you have a valid appeal, and will notify you of the next steps specific to your appeal and the scheduling of your hearing.

- **Amending your Claim:** You may amend your claim in the future if your circumstances change and you have new information to provide to the VCF that you believe warrants additional compensation. The VCF website has important information about the specific circumstances when it is appropriate to request an amendment. For more information and examples of such situations, please refer to “Section 5 – Amendments” in the VCF Policies and Procedures document available under “Forms and Resources” on the VCF website. Please review the information carefully when deciding whether to amend your claim. If you submit an amendment, the VCF will review the new information and determine if it provides the basis for a revised decision.
- **Notifying the VCF of new Collateral Source Payments:** You must inform the VCF of any new collateral source payments you receive, or become entitled to receive, such as a change to your disability or survivor benefits, as this may change the amount of your award. If you notify the VCF within 90 days of learning of the new collateral source payment, your award will not be adjusted to reflect the new entitlement or payment. If you notify the VCF more than 90 days after learning of the new or revised entitlement or payment, the VCF may adjust your award to reflect the new payment as an offset, which



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may result in a lower award. If you need to notify the VCF of a new collateral source payment, please complete the "Collateral Offset Update Form" found under "Forms and Resources" on the www.vcf.gov website.

Your award was calculated using our published regulations, and I believe it is fair and reasonable under the requirements of the VCF Permanent Authorization Act. As always, I emphasize that no amount of money can alleviate the losses suffered on September 11, 2001.

If you have any questions, please call our toll-free Helpline at 1-855-885-1555. For the hearing impaired, please call 1-855-885-1558 (TDD). If you are calling from outside the United States, please call 1-202-514-1100.

Sincerely,

Rupa Bhattacharyya
Special Master
September 11th Victim Compensation Fund



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Award Detail

Claim Number: VCF0048224
Decedent Name: JOSEPH BATTAGLIA

PERSONAL INJURY CLAIM (Losses up to Date of Death)	
Lost Earnings and Benefits	
Loss of Earnings including Benefits and Pension	
Mitigating or Residual Earnings	
Total Lost Earnings and Benefits	\$0.00
Offsets Applicable to Lost Earnings and Benefits	
Disability Pension	
Social Security Disability Benefits	
Workers Compensation Disability Benefits	
Disability Insurance	
Other Offsets related to Earnings	
Total Offsets Applicable to Lost Earnings	\$0.00
Total Lost Earnings and Benefits Awarded	\$0.00
Other Economic Losses	
Medical Expense Loss	
Replacement Services	
Total Other Economic Losses	\$0.00
Total Economic Loss	\$0.00
Total Non-Economic Loss	
Subtotal Award for Personal Injury Claim	



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DECEASED CLAIM (Losses from Date of Death)	
Loss of Earnings including Benefits and Pension	[REDACTED]
Offsets Applicable to Lost Earnings and Benefits	
Survivor Pension	[REDACTED]
SSA Survivor Benefits	[REDACTED]
Worker's Compensation Death Benefits	[REDACTED]
Other Offsets related to Earnings	[REDACTED]
Total Offsets Applicable to Loss of Earnings and Benefits	\$0.00
Total Lost Earnings and Benefits Awarded	[REDACTED]
Other Economic Losses	
Replacement Services	[REDACTED]
Burial Costs	[REDACTED]
Total Other Economic Losses	\$0.00
Total Economic Loss	[REDACTED]
Non-Economic Loss	
Non-Economic Loss - Decedent	[REDACTED]
Non-Economic Loss - Spouse/Dependent(s)	[REDACTED]
Total Non-Economic Loss	[REDACTED]
Additional Offsets	
Social Security Death Benefits	[REDACTED]
Life Insurance	[REDACTED]
Other Offsets	[REDACTED]
Total Additional Offsets	[REDACTED]
Subtotal Award for Deceased Claim	[REDACTED]



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Subtotal of Personal Injury and Deceased Claims	
PSOB Offset	
Prior Lawsuit Settlement Offset	
TOTAL AWARD	
Factors Underlying Economic Loss Calculation	
Annual Earnings Basis (without benefits)	
Percentage of Disability attributed to Eligible Conditions - applicable to Personal Injury losses	
Start Date of Loss of Earnings Due to Disability - applicable to Personal Injury losses	

Eligible Conditions Considered in Award
Malignant Neoplasm - Lung With Metastasis

* D 0 0 3 8 9 1 9 *

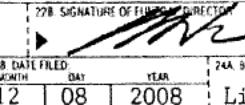
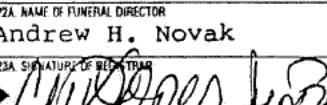
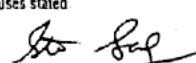
DOH-1961 (10/2009)

RECORDED DISTRICT
2908
REGISTER NUMBER
767

NEW YORK STATE
DEPARTMENT OF HEALTH

STATE FILE NUMBER

CERTIFICATE OF DEATH

1. NAME FIRST MIDDLE LAST		2. SEX: MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	3. DATE OF DEATH: MONTH 12 DAY 05 YEAR 2008	4. HOUR 7:58 P
Joseph L. Battaglia				
4A. PLACE OF DEATH: HOSPITAL <input type="checkbox"/> DOA <input type="checkbox"/> ER <input type="checkbox"/> OUTPATIENT <input checked="" type="checkbox"/> HOSPITAL (PATIENT) <input type="checkbox"/> NURSING HOME <input type="checkbox"/> PRIVATE RESIDENCE <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/>		4B. IF FACILITY, DATE ADMITTED: MONTH 11 DAY 24 YEAR 2008		4C. COUNTY OF DEATH: Nassau
4C. NAME OF FACILITY: (If not facility, give address) Winthrop University Hospital <input checked="" type="checkbox"/>		4D. LOCALITY: (Check one and specify) CITY VILLAGE TOWN Mineola		4E. COUNTY OF DEATH: Nassau
4F. MEDICAL RECORD NO. 788233		4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO <input type="checkbox"/> YES <input type="checkbox"/>		
5. DATE OF BIRTH: MONTH 53 DAY 00 YEAR 1900-2008		6A. AGE IN YEARS: ENTER MONTHS 00 ENTER DAYS 00 ENTER HOURS 00 MINUTES 00	6B. IF UNDER 1 YEAR: ENTER MONTHS 00 ENTER DAYS 00 ENTER HOURS 00 MINUTES 00	7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Brooklyn, New York
				7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:
8. DECEASED IN U.S. ARMED FORCES? (Specify rank) NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> 1900-2008		9. DECEASED OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino (Specify) <input type="checkbox"/>		10. DECEASED'S RACE: Check one or more race to indicate what the decedent considered himself or herself to be. A. <input checked="" type="checkbox"/> White/Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> American Indian or Alaska Native (Specify) <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Other (Specify)
11. DECEASED'S EDUCATION: Check the box that best describes the highest degree or level of school completed at the time of death		1 <input type="checkbox"/> 5th grade 2 <input type="checkbox"/> 6th-12th grade, no diploma 3 <input type="checkbox"/> High school graduate or GED 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate's degree 6 <input checked="" type="checkbox"/> Bachelor's degree 7 <input type="checkbox"/> Master's degree 8 <input type="checkbox"/> Doctorate/professional degree		
12. SOCIAL SECURITY NUMBER: <input type="checkbox"/>		13. MARITAL STATUS: NEVER MARRIED <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/>		14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is widowed, enter maiden name Patricia Ann Byrnes
15A. USUAL OCCUPATION: (Do not enter retired) Uniformed Services		15B. KIND OF BUSINESS OR INDUSTRY: United States Gov't		15C. NAME AND LOCALITY OF COMPANY OR FIRM: Coast Guard Long Island NY
16A. RESIDENCE: (State or County) <input type="checkbox"/> not USA		16B. COUNTRY OR REGION/PROVINCE: <input type="checkbox"/> not USA		16C. LOCALITY: (Check one and specify) CITY VILLAGE TOWN <input type="checkbox"/>
16D. STREET AND NUMBER OR RESIDENCE: <input type="checkbox"/>				16E. ZIP CODE: <input type="checkbox"/>
17. NAME OF FATHER: FIRST Joseph MI J. LAST Battaglia		18. MAIDEN NAME OF MOTHER: FIRST Lucille MI J. LAST Orologio		
19A. NAME OF INFORMANT: Robert Perez		19B. MAILING ADDRESS: (Include zip code) <input type="checkbox"/>		
20A. 15D. RURAL <input type="checkbox"/> Cremation <input type="checkbox"/> Memorial <input type="checkbox"/> Hold <input type="checkbox"/> Donation <input type="checkbox"/> Year <input type="checkbox"/> Entombment <input type="checkbox"/> 12 09 2008		20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: St. Johns Cemetery		20C. LOCATION: (City or town and state) Middle Village, NY
21A. NAME AND ADDRESS OF FUNERAL HOME: Star of David M/C 1236 Wellwood Ave West Babylon NY 11704				21B. REGISTRATION NUMBER: 01672
22A. NAME OF FUNERAL DIRECTOR: Andrew H. Novak		22B. SIGNATURE OF FUNERAL DIRECTOR: 		22C. REGISTRATION NUMBER: 02709
23A. SIGNATURE OF CERTIFYING PHYSICIAN: 		23B. DATE FILED: MONTH 12 DAY 08 YEAR 2008	24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Lisa D Farrell, Sub Reg. 12 08 2008	24B. DATE ISSUED: MONTH 12 DAY 08 YEAR 2008
ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER				
25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated. Certifier's Name: Steve Salzman, MD License No. 158297 Signature:  Month 12 Day 06 Year 2008				
25B. If certifier is not a physician, enter Coroner's Physician's name & title: Address: 222 STATION PLAZA NUTLEY, NEW YORK, NY 11501				
25C. If certifier is not attending physician, enter Attending Physician's name & title: License No. Signature: Month Day Year				
26A. Attending physician attended deceased Month 12 Day 04 Year 2008 to Month 12 Day 05 Year 2008 26B. Decedent last seen alive by Attending physician Month 12 Day 05 Year 2008				
26C. PROFESSION: DOB: Month 12 Day 05 Year 2008				
27. MANNER OF DEATH: NATURAL CAUSE <input type="checkbox"/> ACCIDENT <input type="checkbox"/> HOMICIDE <input type="checkbox"/> SUICIDE <input type="checkbox"/> UNDETERMINED <input type="checkbox"/> CIRCUMSTANCES <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> 28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? NO <input type="checkbox"/> YES <input type="checkbox"/> 29A. AUTOPSY? NO <input type="checkbox"/> YES <input type="checkbox"/> 29B. IF YES, WHERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? NO <input type="checkbox"/> YES <input type="checkbox"/>				
30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B) AND (C)) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I: IMMEDIATE CAUSE: (A) Respiratory Failure (B) Due to or as a consequence of Lung Cancer (C) Due to or as a consequence of				
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A)				
31A. IF INJURY DATE: MONTH DAY YEAR		31B. INJURY LOCALITY: (City or town and county and state)		31C. DESCRIBE HOW INJURY OCCURRED
31D. PLACE OF INJURY: NO <input type="checkbox"/> YES <input type="checkbox"/> PROBABLY <input type="checkbox"/> UNKNOWN		31E. INJURY AT WORK? NO <input type="checkbox"/> YES <input type="checkbox"/>		31F. DATE OF DELIVERY: MONTH DAY YEAR
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 <input type="checkbox"/> Driver/Carrier 2 <input type="checkbox"/> Passenger 3 <input type="checkbox"/> Pedestrian 4 <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/>		32. WAS DECEDED HOSPITALIZED IN: NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> 33A. IF FEMALE: NO <input type="checkbox"/> YES <input type="checkbox"/> 33B. IF PREGNANT: NO <input type="checkbox"/> YES <input type="checkbox"/> 33C. IF PREGNANT AND PREGNANT WITHIN 12 DAYS OF DEATH: NO <input type="checkbox"/> YES <input type="checkbox"/> 33D. IF PREGNANT AND PREGNANT WITHIN 3 DAYS OF DEATH: NO <input type="checkbox"/> YES <input type="checkbox"/> 33E. IF PREGNANT AND PREGNANT WITHIN 1 YEAR OF DEATH: NO <input type="checkbox"/> YES <input type="checkbox"/>		

For use by physician or hospital.

NAME OF DECEDENT: DATE OF DEATH: AM/ PM

TIME OF DEATH: DATE:

Family Member Affidavits

Patricia Byrnes

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----- X

In Re:

TERRORIST ATTACKS ON
SEPTEMBER 11, 2001

03-MDL-1570 (GBD)(SN)

----- X
RAYMOND ALEXANDER, et al.,

AFFIDAVIT OF
PATRICIA BYRNES

Plaintiffs,

21-CV-03505 (GBD)(SN)

V.

ISLAMIC REPUBLIC OF IRAN,

Defendant.

----- X

STATE OF FLORIDA)
: SS
COUNTY OF PASCO)

PATRICIA BYRNES, being duly sworn, deposes and says:

1. I am a plaintiff in the within action, am over 18 years of age, and reside at
[REDACTED] [REDACTED]

2. I am currently 65 years old, having been born on [REDACTED] [REDACTED]

3. I am the wife of Decedent, Joseph L. Battaglia, upon whose death my claims are based. I submit this Affidavit in support of the present motion for a default money judgment for the claim made on behalf of my husband's estate and for my solatium claim. On August 5, 2009, I was issued Letters of Administration as Administrator of my husband's estate by the Nassau County Surrogate's Court

4. My husband passed away from Lung Cancer on December 5, 2008, at the age of 53. It was medically determined that this illness was causally connected to his exposure to the toxins resulting from the September 11, 2001, terrorist attacks at the World Trade Center.

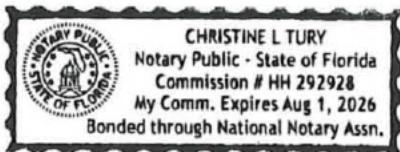
5. Joe and I were married in 1985. We had two children together. For over 24 years he was my heart and soul. We were very happy. He was a police officer with the NYPD for over 20 years. Once he retired in January 2001, we were able to start traveling and doing things with the family that every couple plans to do. He was in the Coast Guard Rescue and enjoyed being with the military for over 20 years. Joe was a very helpful partner when it came to raising our children. He did many things with them. He was President of Little League and the Boy Scout Leader. Our children needed their father's guidance in their young lives.

6. On September 11, 2001, Joe was activated by the Coast Guard to Station Shinnecock in Hampton Bays, New York and responded by the coast guard boat to the waters off the WTC to Coast Guard Station New York. He assisted in the efforts of recovery, transporting of people, and aid to the vessels participating in the tragic recovery effort. His DD214 documents state his presence from September 11, 2001, through October 5, 2001, at the Coast Guard Station in New York for Operation Noble Eagle. He returned to active duty from March 10, 2003, through January 31, 2005, to activities in Staten Island, in the detachment Bayonne in support of Operation Iraqi Freedom, in which his unit assisted in transport of debris from WTC site, port security boardings, and vessel inspections for WTC responding patrols.

7. On November 24, 2008, Joe was taken to the emergency room with breathing problems. He was diagnosed with pneumonia and had extremely difficult time breathing because of the water in his lungs. They did many tests that night and by morning the X-Rays showed what would be confirmed as lung cancer with many abnormal tumors throughout his body. He

underwent surgery to drain the fluid from his lungs and to biopsy some of the tumors. My husband struggled to breathe for 11 days before he fell into a coma on December 4th and after receiving devastating biopsy results. I ended life support on December 5, 2008, upon the onset of the pneumonia with breathing problems. He could not talk to anyone and in the end, he was not able to say final goodbyes to any family.

8. Joe's death had a profound effect on my life. I lost my life partner and the father of my children. I lost the dreams of a life together. With his death, his police pension ended which was the principal support of our household. I received a small annuity from the Coast Guard of \$275.00 a month. I still had to return to work full-time. My way of life was forever changed with the loss of a husband and partner to raise my children with.



Pat A. Byrnes
PATRICIA BYRNES

Sworn before me this

24th day of September, 2023

[Signature]
Notary public